DRAFT

Arkansas Payment Improvement Initiative

Cross-Episode Update

March 28th, 2012
3:30pm – 6pm

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Welcome

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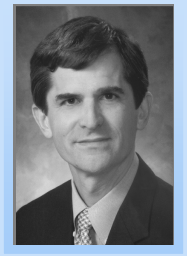

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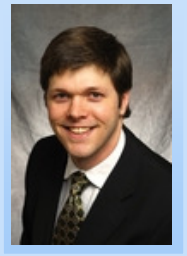

David Nuzum

Partner
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Today's objectives

Share Payment Improvement Initiative background

- Recap of episode approach, payment model
- Discuss patient and provider level adjustments to payment
- Review quality and data reporting / exchange
- Review timing of next steps

Workgroups have identified many ways in which the fee-for-service model fails to reward high-quality care

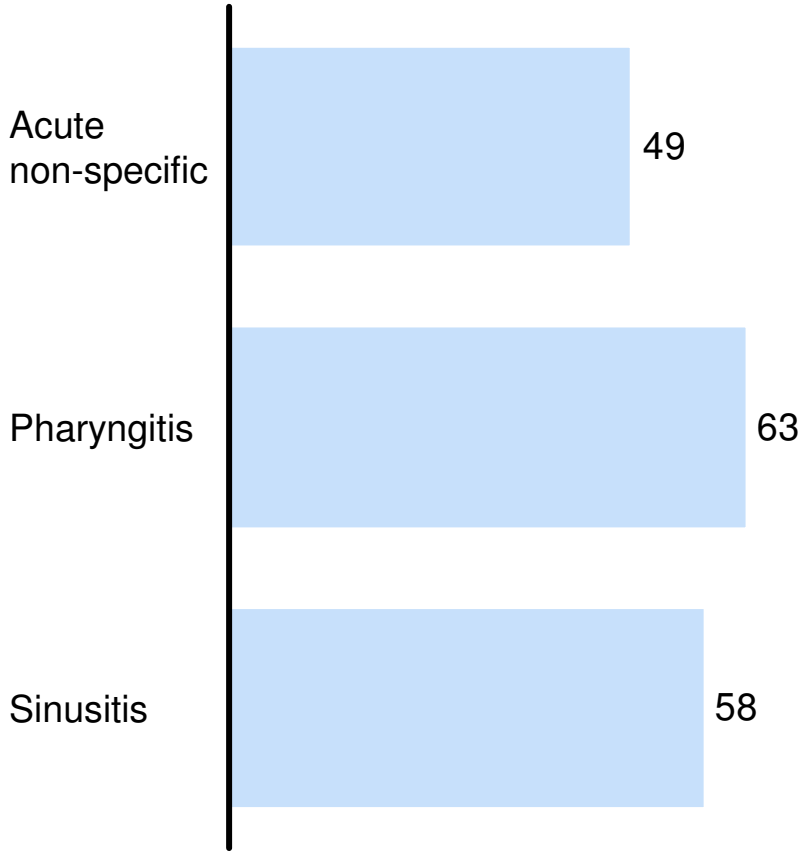
Limitations of fee-for-service model	Examples from workgroups
No accountable provider for care coordination	▪ Different segments of pregnancy/NICU care – the prenatal phase, delivery, and postnatal care for the mother – may be delivered by multiple, uncoordinated providers
Insufficient investment in patient education	▪ Hospitals treating patients with congestive heart failure are not rewarded for high-quality transition education at discharge
Evidence-based medicine not rewarded	▪ Nearly 50% of adults receiving care for simple upper respiratory infections in Arkansas receive antibiotics, even though evidence-based guidelines suggest prescribing very selectively, if at all
Significant administrative burdens	▪ Developmental Disabilities providers must maintain detailed activity logs for compensation, spending considerable resources on non-care activities

What challenges are we trying to address? URI example

MEDICAID DATA

Antibiotic prescription rates for adults are high…

% of episodes resulting in filled antibiotic[1]



…yet evidence-based guidelines suggest prescribing very selectively, if at all

- "Antibiotics should not be used to treat **nonspecific upper respiratory tract infections** in adults, since antibiotics do not improve illness resolution"
- "For **acute pharyngitis,** antibiotic use should be limited to patients who are most likely to have group a β-hemolytic streptococcus"
- "For **acute sinusitis,** narrow-spectrum antibiotics should be given only to patients with persistent purulent nasal discharge and facial pain or tenderness who have not improved after 7 days or those with severe symptoms."

CDC guidance[2]

1 ICD-9 034.0 not included in analysis. All patients with tonsil-related procedures and outpatient observations in hospitals excluded

2 From CDC, summarized in Gill et. al., "Use of Antibiotics for Adult Upper Respiratory Infections in Outpatient Settings: A National Ambulatory Network Study" (2006) (internal citations removed)

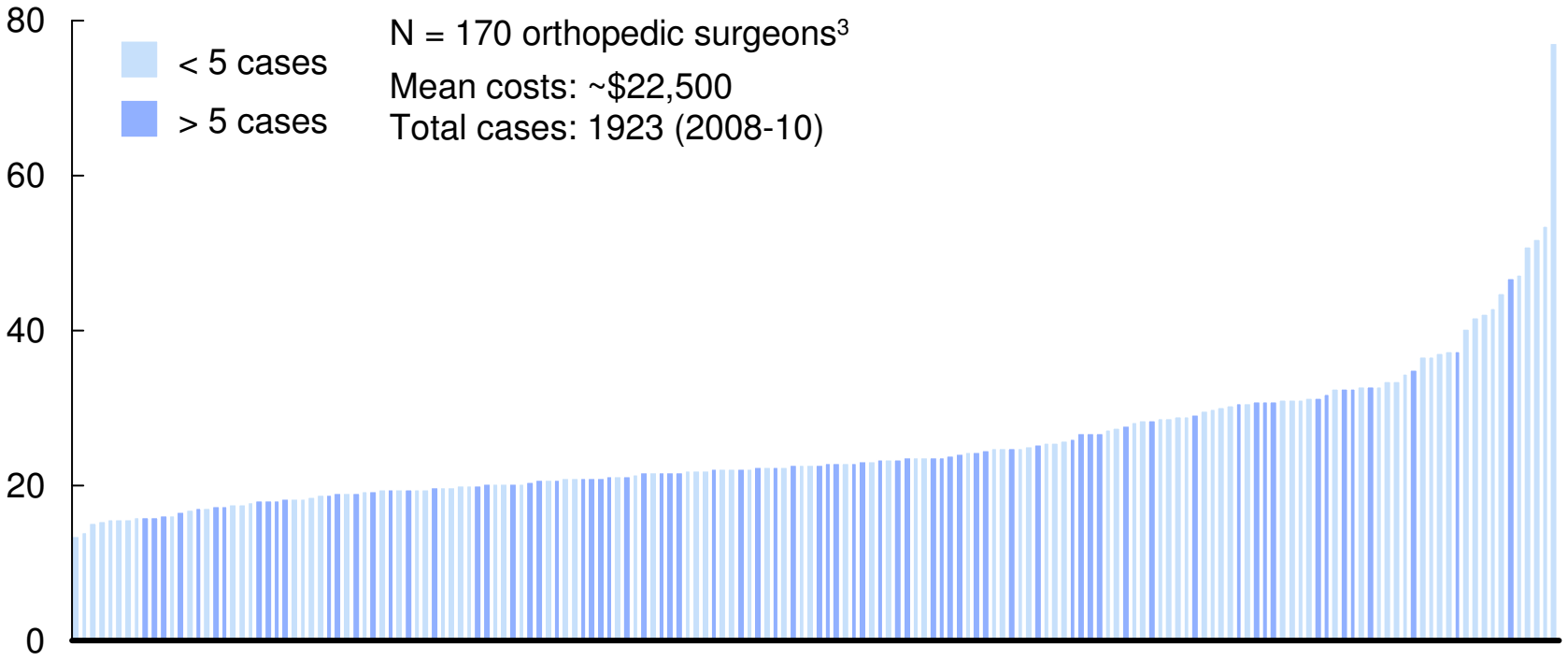
SOURCE: Medicaid claims SFY2010; CDC

Example current practice: Variation in total knee replacement episode cost by treating orthopedic surgeon

BCBS DATA

Average episode cost[1] for total knee replacements in Arkansas attributed by orthopedic surgeon[2]

$ Thousands



1 Episode costs identified using Ingenix ETG grouper
2 Each bar represents case outcomes for individual orthopedic surgeon performing hip or knee replacement procedure
3 Excludes episodes without claims for in-patient facility costs (<3% of cases each for THR and TKR)

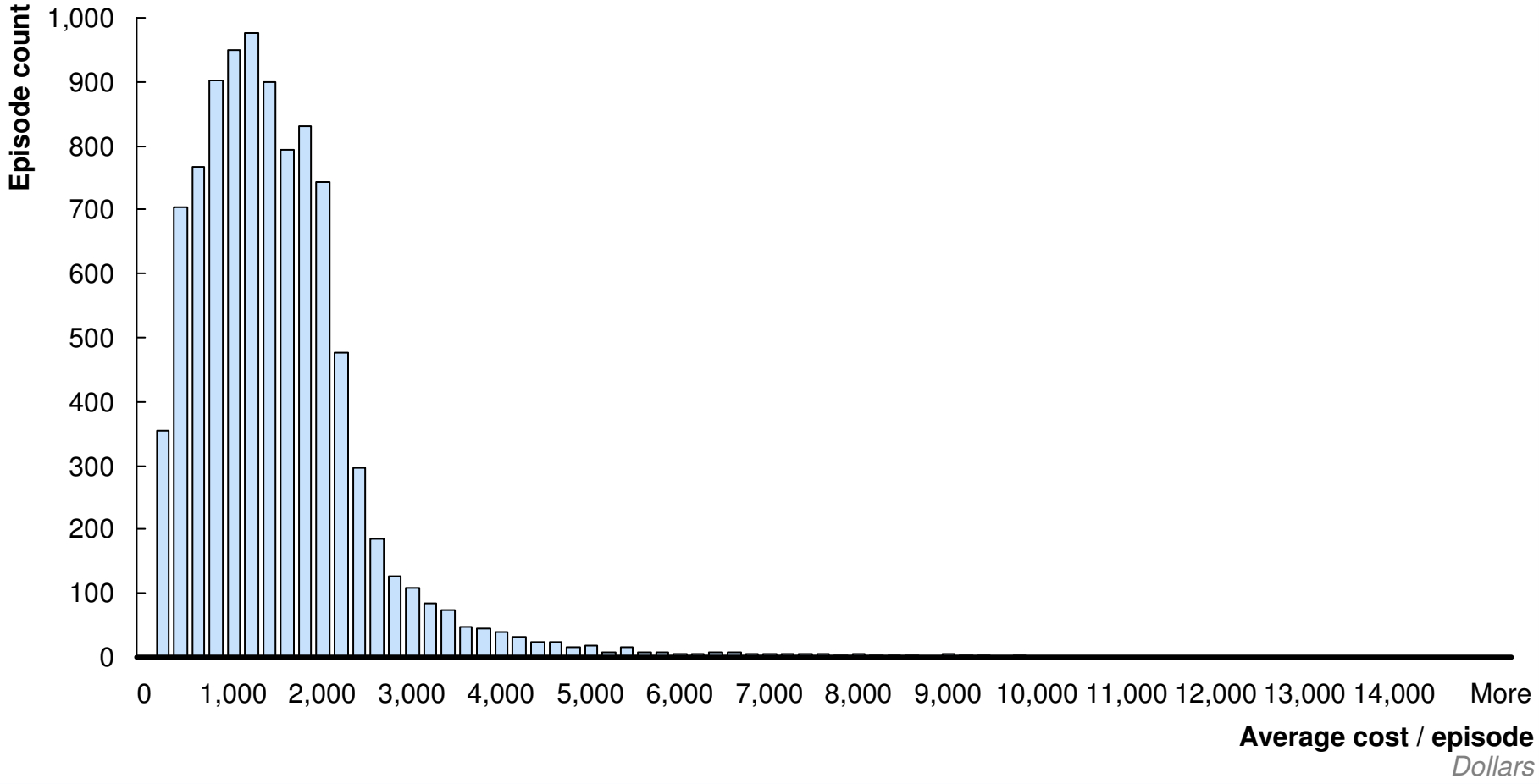
SOURCE: Arkansas BCBS claims data (from 12/31/2007 to 12/31/2010), team analysis

Example current practice: ADHD episode cost distribution for episodes with physician as Principal Accountable Provider[1]

MEDICAID DATA

Episodes ending in SFY 2009 – SFY 2010 (i.e two years of data), Medicaid only

Episode cost distribution for eligible episodes, physician PAPs (patients aged 6 – 17, no BH comorbid conditions)
Average cost / episode ($), Medicaid only



SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services

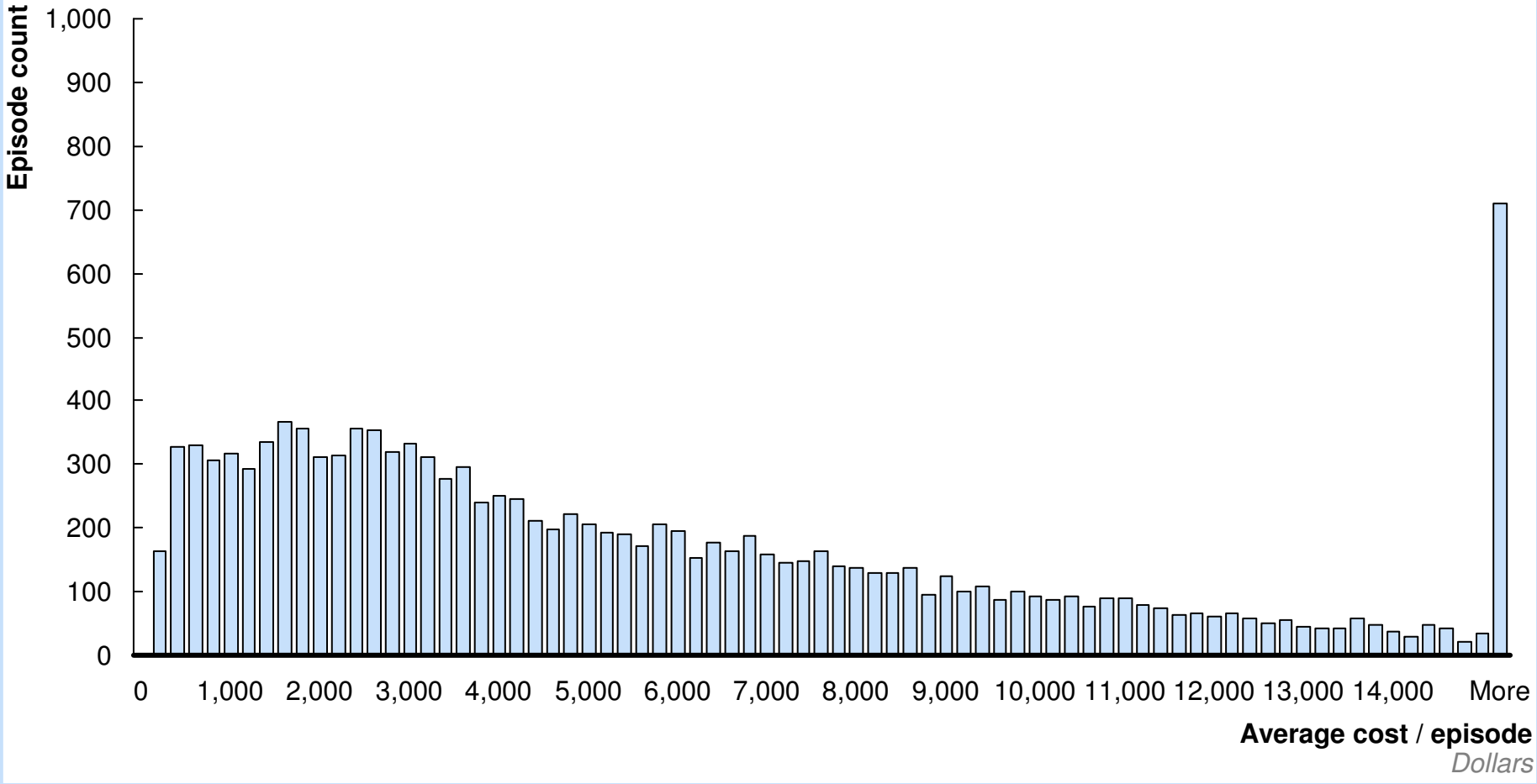
Example current practice: ADHD episode cost distribution for episodes with RSPMI provider organizations as Principal Accountable Provider

Episodes ending in SFY 2009 – SFY 2010 (i.e two years of data), Medicaid only

MEDICAID DATA

Episode cost distribution for eligible episodes, RSPMI PAP (patients aged 6 – 17, no BH comorbid conditions)

Average cost / episode ($), Medicaid only



SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services

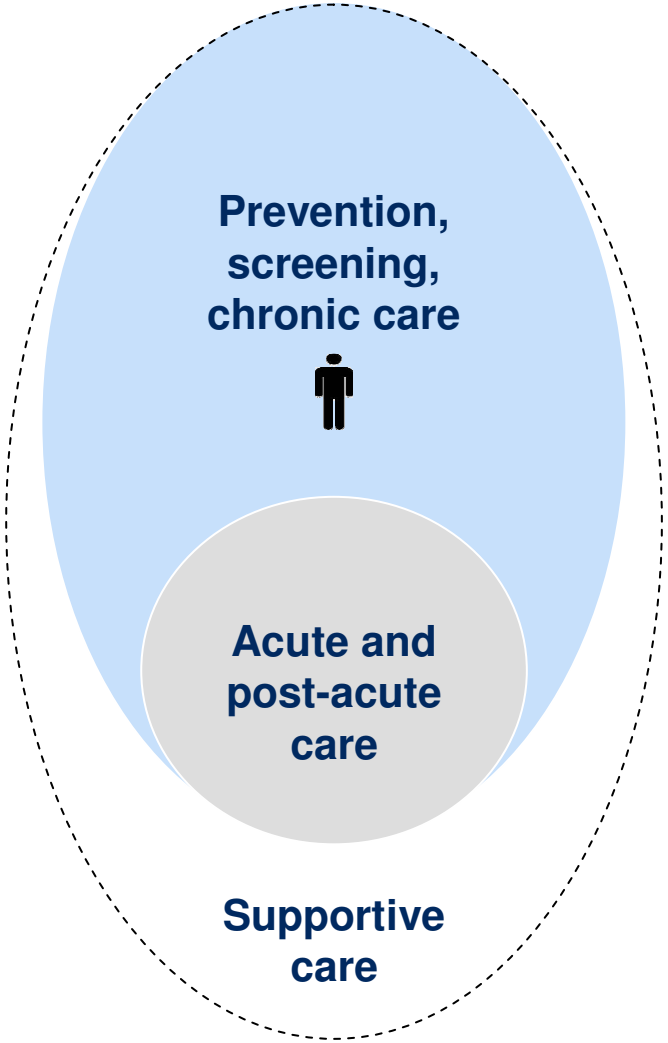
Goals of Payment Initiative compared with fee-for-service

- ✓ Reward high-quality care and outcomes
- ✓ Encourage clinical effectiveness
- ✓ Promote early intervention and coordination to reduce complications and associated costs
- ✓ Encourage referral to higher-value downstream providers

Principles of payment design for Arkansas

Patient-centered	Focus on improving quality, patient experience and cost efficiency
Clinically appropriate	Evidenced-based design with close input from Arkansas patients, family members, and providers
Practical	Consider scope and complexity of implementation
Data-based	Make design decisions based on facts and data

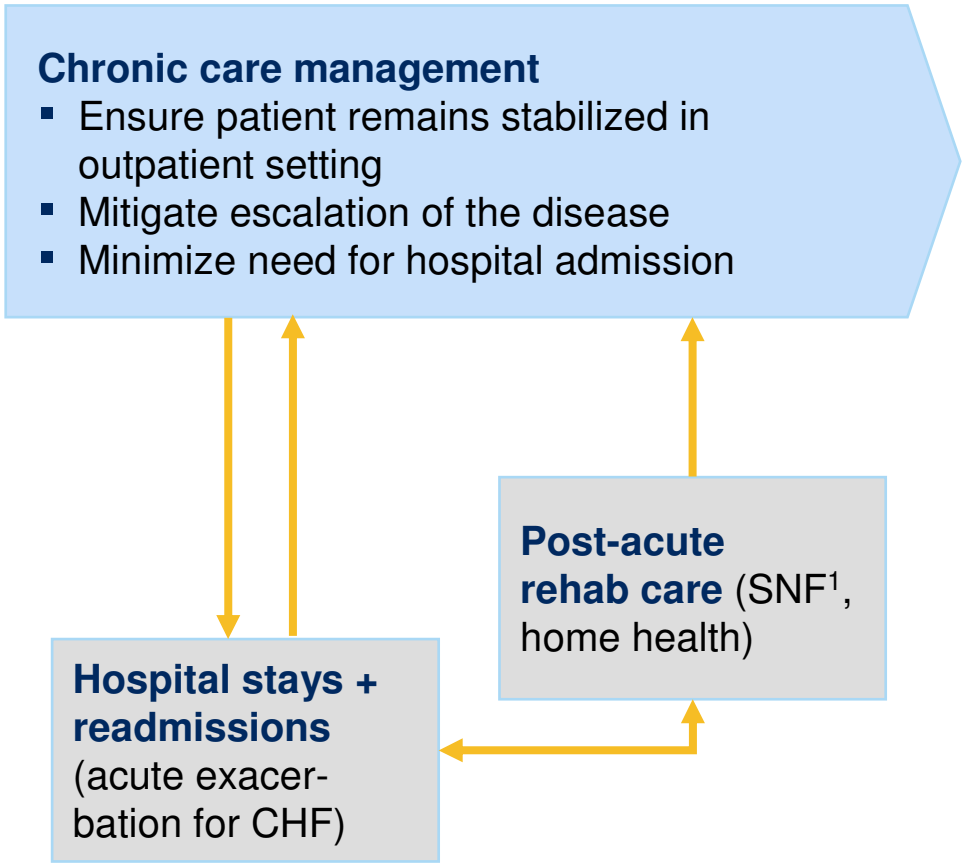
The populations that we serve require care falling into three domains



Patient populations (examples)	Care/payment models
• Healthy, at-risk • Chronic, e.g., – CHF – Diabetes	**Population-based**: medical homes responsible for care coordination, rewarded for quality, utilization, and total care cost
• Acute medical, e.g., – CHF – Pneumonia • Acute procedural, e.g., – Hip replacement	**Episode-based***:* gain and risk sharing with one or more providers, rewarded for quality and savings relative to cost thresholds
• Developmental disabilities • Long-term care • Behavioral health (mental illness / substance abuse)	**Combination of population- and episode-based models***:* health homes responsible for care coordination; episode-based payment for care provision

Example of how population-based and episode-based models link

EXAMPLE: CONGESTIVE HEART FAILURE



- Stabilize a hospitalized patient and reintegrate back into medical home

Population-based medical home

- Care coordination processes target CHF and other high-risk populations
- Performance measurement and rewards evaluated across all conditions, not unique to CHF

CHF acute + post-acute episode

- Episode-based payment from initial admission until fixed period post-discharge, inclusive of readmits

1 Skilled nursing facility

Focus of Wave 1 episodes

WORKING DRAFT

	Episodes	Definition / scope of services
Focus of today's discussion	**Hip/knee replacements**	▪ Surgical procedure plus all related claims from 30 days prior to procedure to 90 days after
	Perinatal (non NICU)	▪ Pregnancy-related claims for mother from 40 weeks before to 60 days after delivery ▪ Excludes neonatal care
	Ambulatory URI	▪ 21-day window beginning with initial consultation and including URI-related outpatient and pharmacy costs ▪ Excludes inpatient costs and surgical procedures
	Acute/post-acute CHF	▪ Hospital admission plus care within 30 days of discharge
	ADHD	▪ 12-month episode including all ADHD services and pharmacy costs with exception of initial assessment
	Developmental disabilities[1]	▪ Assessment or annual review plus 12 months of DD services

1 Developmental disabilities will use a model which varies from that used for the other five episodes.

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An overview of the episode payment model

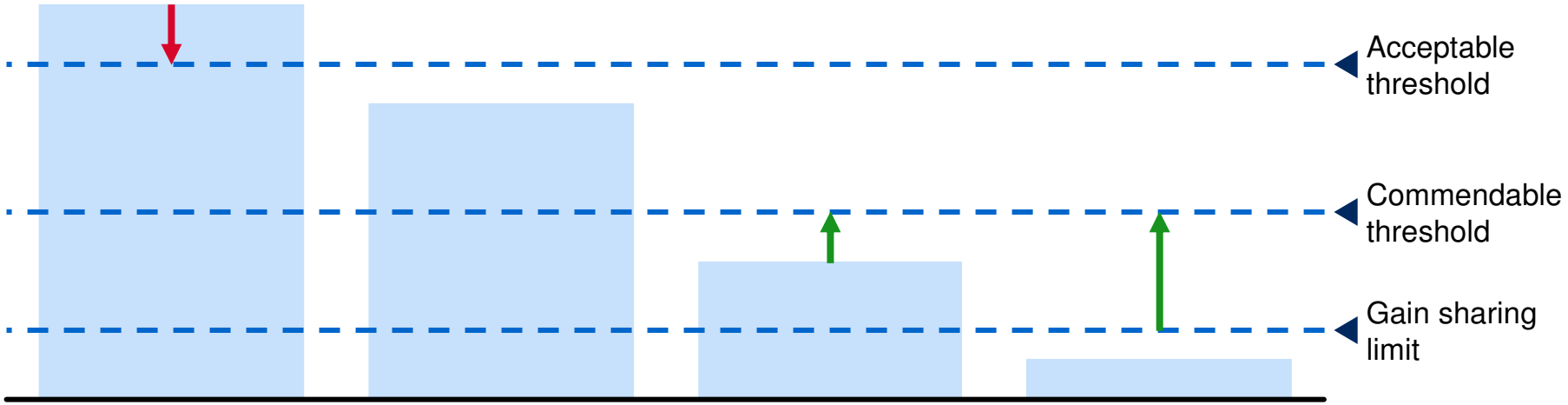
How does payment work?	▪ All providers submit claims as today ▪ A principal accountable provider (PAP) for each episode has main responsibility for ensuring episode is delivered at appropriate cost and quality ▪ PAP and payor share savings or excess costs
Who is the PAP?	▪ Payors designate the PAP based on three criteria: – Main decision maker for most care during episode – Ability to coordinate or direct other providers delivering care – Meaningful share of costs or volumes
How do we make this fair to all providers?	▪ Aim is to include as much care as possible under this system, but: – Some patient episodes will be **excluded** – Some **adjustments** will be made to costs (e.g., stop-loss) ▪ This will always be with the aim of ensuring quality care for patients and making the payments fair to providers
How does quality figure in the payment model?	▪ To meet the quality bar, providers will need to: – Meet specific thresholds for a set of metrics – Provide data on a set of metrics ▪ Claims-based quality metrics will also be tracked and reported ▪ Payors will selectively audit data for accuracy

How the episode payment model works: three steps

Before start of reporting period	*During period*	*At end of period*
A Establish thresholds for episode	**B Determine actual total cost of episodes**	**C Distribute gains or costs to principal accountable provider(s)**
▪ Set quality thresholds ▪ Set acceptable and commendable cost performance thresholds for episode ▪ Share with providers	▪ Reimburse each provider based on fee schedule for services rendered ▪ Calculate total cost of each episode, inclusive of relevant services and providers	▪ Compare average episode quality and cost during the period against the thresholds ▪ Distribute additional gain-share or risk share to principal accountable provider(s)

How we will work out whether the PAP can receive gain-share

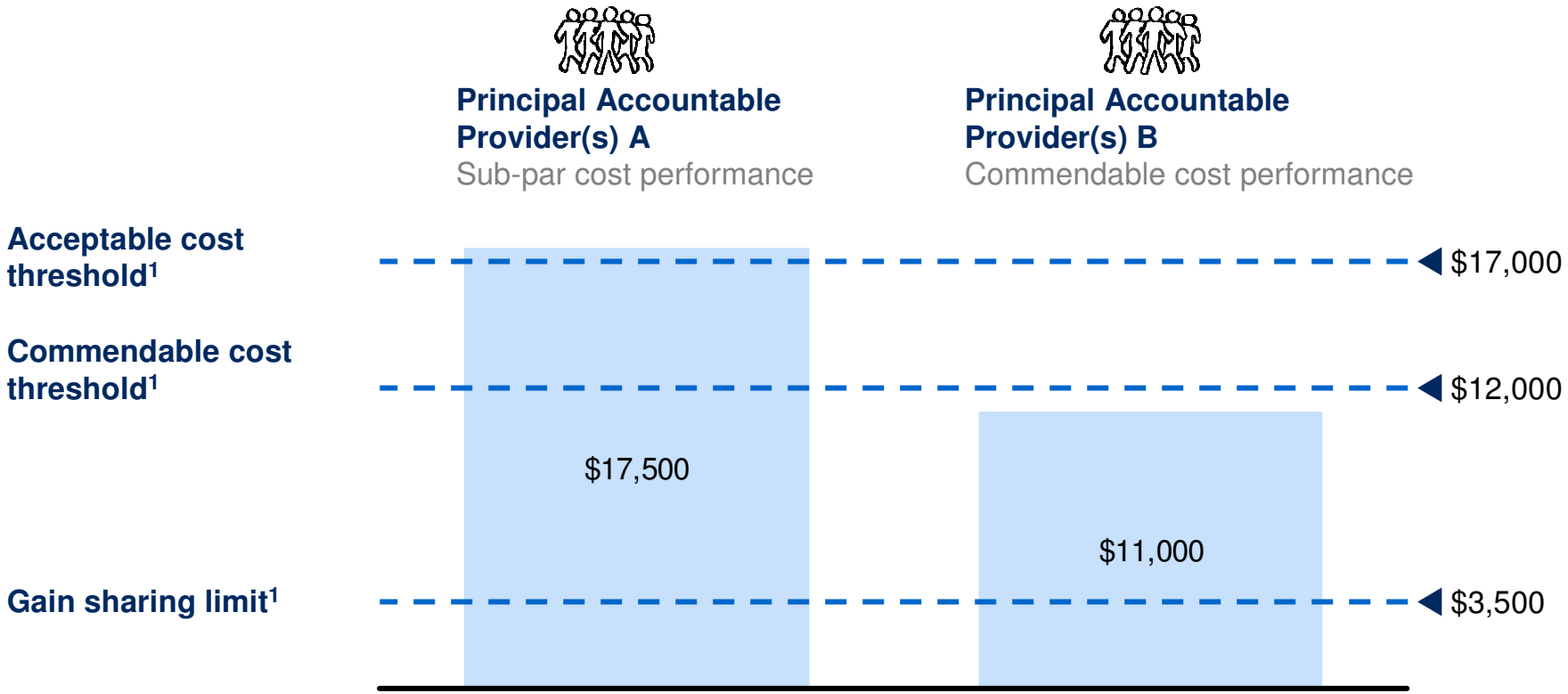
Average cost per episode for each Principal Accountable Provider (PAP), at satisfactory quality level



Sub-par performance	Acceptable performance	Commendable performance	Beyond commend-able performance
Providers whose costs exceed the acceptable threshold will be held **responsible for a share of costs above this threshold** – shown by the arrow above	The provider **neither gains nor loses** because costs are neither above the acceptable threshold nor below the commendable threshold	**Savings** below the commendable threshold – shown by the arrow above– **are shared** between provider and payor, until the gain sharing limit is reached	The provider will receive a share of **savings up to a gain sharing limit, but not beyond**

Note: in the coming months, each participating payor will determine the level of upside and downside sharing for each episode

Episode payment model: illustrative example



Amount of gain or risk sharing

- Average episode cost is $500 above acceptable threshold
- Excess cost is divided between payor and PAP

- Average episode cost is $1000 below acceptable threshold
- The PAP shares this gain with the payor, so long as quality measures are satisfactory

1 May be risk-adjusted. For simplicity of illustration, all patients in this example are of the same level of severity

Note: in the coming months, each participating payor will independently determine cost thresholds and level of upside/downside sharing for each episode

Defining the roles of providers

Principal accountable provider(s) (PAP)

- Provider(s) with which payor directly shares upside/downside for cost relative to thresholds
- Receives performance reports, organizes team to drive performance improvement
- Continues to submit claims as today
- Reports selected data (e.g., on quality)
- May be physician practice, hospital, or other provider
  - Designation varies between episodes

Participating provider(s) (PP)

- Any provider that delivers services during an episode that is not a PAP
- Continues to submit claims as today
- Do not directly share in upside/risk for cost relative to thresholds
- May or may not receive performance reporting from payor or PAP

Candidate principal accountable providers across episodes

WORKING DRAFT

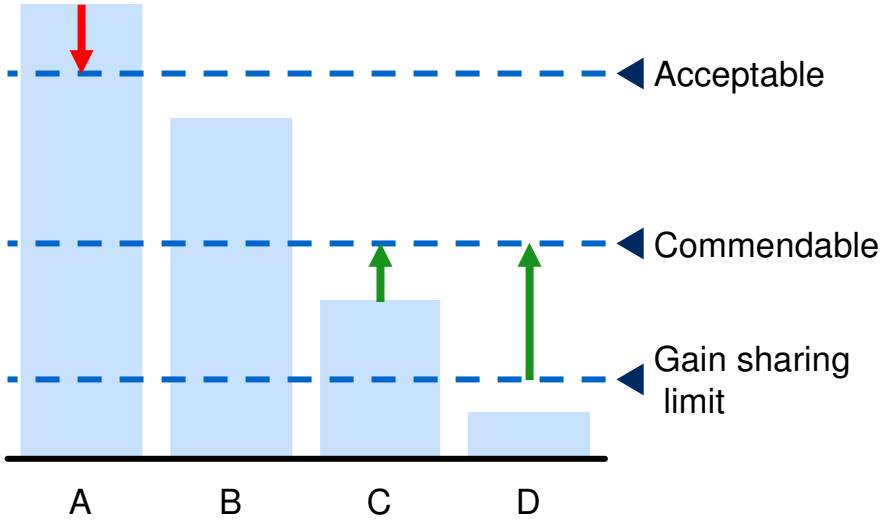
	Candidate principal accountable provider(s)[1]
Hip/knee replacements	▪ Orthopedic surgeon ▪ Hospital
Perinatal (non NICU)	▪ Delivering provider ▪ If separate providers perform prenatal care and delivery, both providers are PAPs (shared accountability)
Ambulatory URI	▪ Provider for the first in-person URI consultation
Acute/post-acute CHF	▪ Hospital
ADHD	▪ Could be the PCP, mental health professional, and/or the RSPMI provider organization, depending on the pathway of care
Developmental disabilities	▪ Primary DD provider[2]

1 Based on objective assessment of PAP criteria; participating payors will make own assessment of which providers to designate as PAP
2 For DD, Lead Provider will be chosen and is responsible for coordination across integrated care plan & reporting / performance on quality metrics

We are starting off by giving providers time to adjust

Transition period

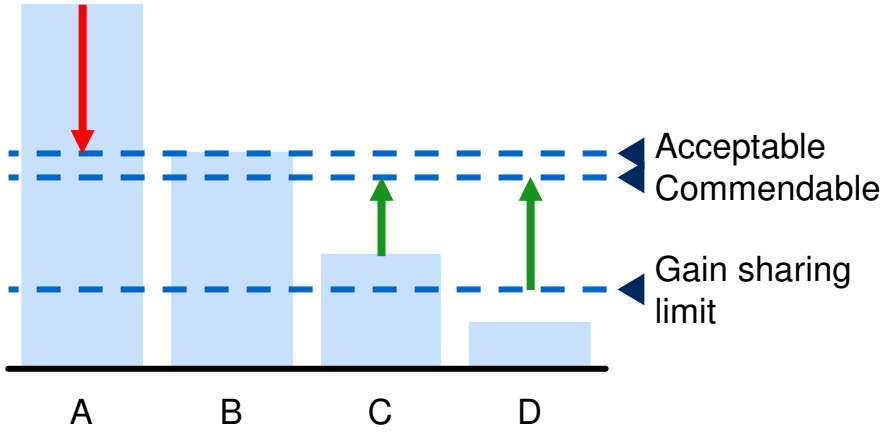
Average cost per episode, for each Principal Accountable Provider, at satisfactory quality



- Higher acceptable threshold (fewer providers exposed to downside risk)
- Providers begin implementing practice changes to meet outlined post-transition thresholds

Post-transition period

Average cost per episode, for each Principal Accountable Provider, at satisfactory quality



- Acceptable threshold will be brought closer to the commendable threshold
- Commendable threshold will be brought to post-transition level

Guiding principle: give providers the time and resources to change practice patterns and improve performance before full risk and gain sharing is in effect

Today's objectives

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Discuss patient and provider level adjustments to payment

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Version 1.0 episode design will incorporate several design elements common across clinical areas

	Description
A Patient-level adjustments	▪ Patient risk/severity adjustments ▪ Outlier exclusions on a cost basis
B Provider-level adjustments	▪ Stop-loss provisions ▪ Adjustments for providers in areas with poor physician access ▪ Adjustments for cost-based facilities ▪ Adjustments for differences in regional pricing ▪ Adjustments or exclusions for providers with low case-volume

A Patient-level adjustments

Patient risk/severity adjustments

Goal: Cost thresholds will take into account patient severity to the extent possible to be fair to providers with high-risk patients and to avoid any incentive for "cherry-picking"

Approach:

- Identify risk factors via literature, Arkansas experience, and clinical expertise
- Adjust episode cost threshold based on selected risk factors
- Add risk factors over time in line with new research and / or empirical evidence

Outlier exclusions on a cost basis

Goal: Exclude the impact of extreme outlier cases in calculating average cost per episode, so that one or a few cases do not overshadow a provider's long-term performance across a broader population

Approach:

- Cases above a certain cost threshold will be identified as outliers
- Full cost of the outlier will be excluded in calculations for average episode cost

B Provider-level adjustments (1 of 3)

Stop-loss provisions

Goal: Principal accountable providers should have a maximum level of downside risk, calculated across all episodes for which the provider is accountable

Approach:

- A provider's maximum downside across all episodes will not exceed a stop-loss threshold
- That threshold will be set as a % of total overall reimbursement (medical and pharmacy) a provider receives from each payor (for example, 10% of total practice revenue)

Adjustments for providers in areas with poor physician access

Goal: In areas with limited physician access, downside risk may be further limited for some providers in order to avoid adverse financial impact that could undermine patient access to care

Approach:

- Identify provider specialties and zip codes with poor physician access
- Limit the level of upside and downside gain or risk sharing for these providers

B Provider-level adjustments (2 of 3)

Adjustments for cost-based facilities (where applicable)

Goal:

- Version 1.0 of the Payment Reform initiative does not aim to change base reimbursement for those providers currently entitled to cost-based reimbursement (e.g., CAHs, CHCs, nursing facilities, or hospitals)
- However, version 1.0 does place a portion of the base reimbursement for those facilities at risk for episode-related gains and losses

Approach:

- Existing claims payments will not be impacted
- Providers receiving cost-based reimbursement will not be excluded from eligibility/ attribution as principal accountable providers
- Approach is to apply the same approach to gains and risk of loss to all PAPs
- This will apply both when the PAP is a physician and when the PAP is the hospital itself

B Provider-level adjustments (3 of 3)

Adjustments for differences in regional pricing (where applicable)

Goal:

- Individual payors may choose to adjust cost thresholds by region to reflect local variations in negotiated fees and costs of care

Approach:

- Degree of adjustment will vary by individual provider and by episode category

Adjustments or exclusions for providers with low case-volume

Goal:

- Providers whose case-volume includes too few cases to generate a robust measure of performance may be excluded from episode-based payment for that episode

Approach:

- Individual payors will set a minimum case volume for each episode category
- For a given payor and episode category, principal accountable providers who do not meet the minimum case volume will not be eligible for upside or downside gain or risk sharing

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By design, episode-based payment will reward high quality care

Example for a CHF patient admitted to the hospital

Episode-based payment rewards providers for reducing readmissions and therefore:

- Motivates the hospital to stabilize the patient quickly and effectively (fluid levels, medication titration)
- Rewards the hospital for providing effective patient education at discharge
- Rewards the outpatient physician and hospital for working together to ensure an effective handoff, e.g.,
  - Follow-up visit within 48 hours of discharge
  - Medication reconciliation
- Rewards effective coordination of care (home health, case management, other follow up)

Episodic payment inherently rewards quality care by holding providers accountable for downstream outcomes and costs

Episode design may be further augmented with quality metrics

PRELIMINARY

Objectives	Examples
Document evidence-based medicine and practices[1]	▪ Select quality + process metrics, (e.g., % of CHF patients on an ACE or ARB)
Encourage outcomes not directly related to costs within episode	▪ Select quality metrics to track (e.g., 30-day post-admission mortality rate for heart failure patients)
Ensure model will not result in underuse of care	▪ Payment contingent on delivery of universally agreed as critical/ necessary (e.g., % of perinatal episodes with claim for Chlamydia testing)

1 Avoid directly linking performance on specific measures to payment as episodic payment already incents this

Approach to quality metrics

- By design, episode model incents high-quality care
- In addition, we will incorporate two types of **quality metrics** into the episode model
- Some episodes will also have **additional design features** to promote quality

Types of quality metrics

- **Quality metrics "to pass" (linked to payment)**
  (5 or fewer per episode)
- **Quality metrics "to track"**
  (5 or fewer per episode)

- Initially, where possible, will be limited to claims-based metrics
- If non-claims based, reported through a new, user-friendly, internet-based provider portal
- Each metric linked to payment will have a quality threshold that providers must exceed

Providers will regularly receive reports on their performance across both types of quality metrics

Providers will be ineligible to receive upside gain-sharing if they don't:

- Meet quality threshold on all performance metrics
  AND
- Fully report all required data for metrics that require reporting

Current thinking on quality metrics: selected example episodes

PRELIMINARY


Requires provider / clinical data

	Metrics "to pass"	Metrics "to track"
Perinatal	▪ % of episodes with claim for HIV test ▪ % of episodes with claim for GBS test ▪ % of episodes with claim for Chlamydia testing	▪ % of episodes with claim for hepatitis B test ▪ % of episodes with claim for bacteriauria testing ▪ % of episodes with claim for gestational diabetes testing ▪ % of episodes with claim for ultrasounds ▪ % of episodes resulting in Cesarean section
CHF	 % of CHF patients prescribed (or already taking) ACE-inhibitor / ARB therapy for left ventricular systolic dysfunction (LVSD) at hospital discharge	▪ Frequency of outpatient follow-ups within 7 and 14 days post discharge for CHF  Percent of CHF patients with qualitative or quantitative documentation of LVF assessment in the hospital record ▪ 30 day readmission rate for heart failure patients  30-day post-admission (or inpatient) mortality rate for heart failure patients

Approach to reporting

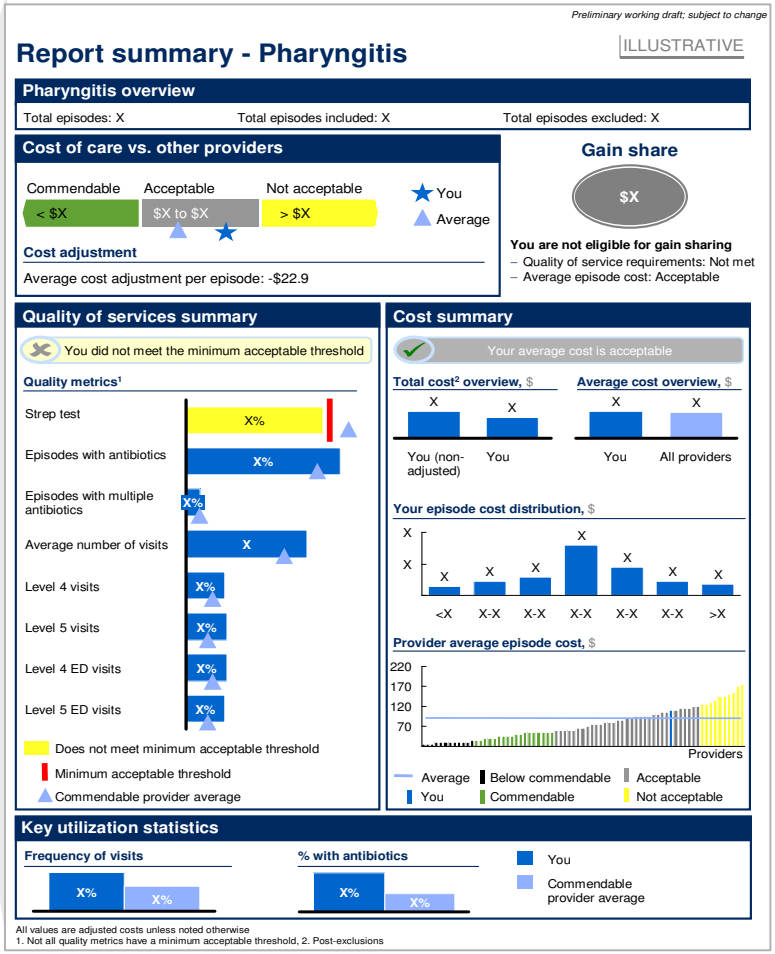
- Performance reports will be issued to PAPs on a **regular basis** (e.g., quarterly) via a secure **Provider Portal**
- Reports will contain performance information related to both **quality and cost**
- Payors will follow a **standard report format**, and include all PAP-relevant episode types in each report. Providers will receive **separate reports from each payor**
- **Episode-level detail** will be provided
- Reports will be issued **regardless of whether minimum caseload has been met**

Example Performance Report

Information included in reports

- **Performance summary**
  - Episode performance and gain / risk sharing amount
  - Quality requirements
- **Report summary**
  - Cost summary and benchmarks
  - Quality of service summary
  - Utilization summary
- **Quality of service:** Detail benchmarks for quality metrics across all PAPs
- **Care categories**
  - Breakdown of episode cost by care category
  - Benchmarks against commendable providers
- **Episode detail:** Cost detail by care category for each individual episode a provider treats
- **Glossary:** Definition and calculation of terminology/metrics used in the report

Illustrative example



Provider Portal overview

- The Provider Portal will be a **provider-friendly, PHI compliant and web-based** tool connecting multiple payors to providers

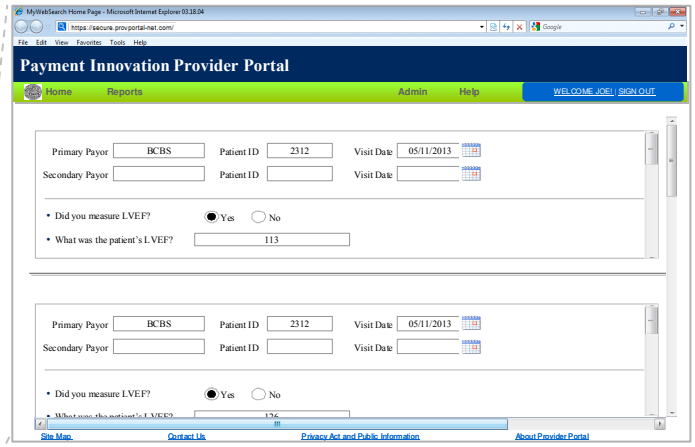
- Providers will use the Provider Portal to
  - Enter **clinical data and certifications** for episodes to augment claims data
  - **Search and review** clinical data on current and past episodes and patients
  - Obtain periodic **performance reports** providing information on providers' cost and quality against benchmarks

Example Provider Portal screen shots

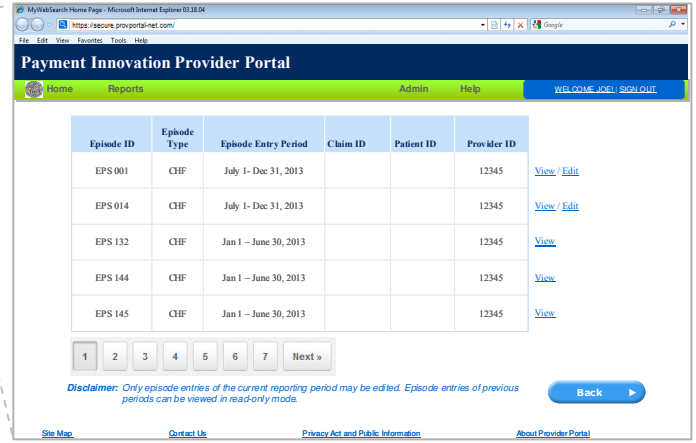
ILLUSTRATIVE

Information included in portal

- **Web-based interface**
  - Access through internet browsers
  - Secure log in
  - Individual (e.g., physician) specific IDs and passwords
- **Clinical data entry**
  - Episode-specific forms
  - User-friendly interface/workflow
- **Episode search and edit**
  - Filters to search previously entered episode information
  - Edit previously entered episode information
- **Access to reports**
  - Including current & previous reports
  - Reports downloadable



- Episode-specific forms for clinical data entry
- Ability to enter data on multiple episodes on a single page



- Search function based on:
  - Episode type
  - Time
  - Patient ID
  - Claims ID

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- Share Payment Improvement Initiative background
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Review timing of next steps

July 1st launch: current thinking

Key milestones	Description	Timing
▪ **Program announcement and education**	▪ Payment design and documentation published ▪ Educational workgroups and townhalls to answer questions	May/ June
▪ **Program launch**	▪ All analytic/ reporting engines up and running	July 1st
▪ **Reporting period (3-6 months)**	▪ Principal Accountable Providers (PAP) begin data exchange and later receive baseline historical performance reports ▪ Analytic/ reporting engines track "virtual" performance for each PAP ▪ Performance does not yet impact payment	July 1st
▪ **Feedback period**	▪ Workgroups provide feedback on version 1.0 ▪ Payors refine version 1.0 design	July 1st – Sep 1st
▪ **Performance period begins**	▪ New episodes begin to count towards a PAP's share of risk or gain sharing	Q4 2012 or Q1 2013

NOTE: Developmental disabilities are on a separate timeline, as described in the workgroup on March 6

Your questions